Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

LES BENSON MD
1220 GUNNISON
WACO TX 76712

Carrier's Austin Representative Box
Box Number 19

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Date Received
December 14, 2010

MFDR Tracking Number
M4-11-1250-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I provided a designated doctor examination of…on 6/25/10 I submitted a bill for this service 9/12/10. I did not receive an EOB or payment within forty-five days. I sent a request for reconsideration on 11/25/10. I received a denial message 200 and 29, the time limit has expired. I have included copies of the original bill (with conformation) and correspondence from Zurich."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider submitted a request for medical dispute resolution on December 14, 2010 for healthcare services provided on June 25, 2010 and is seeking reimbursement in the amount of $350.00. The carrier is in the process of re-auditing the bill. Once this process is completed, it will update the provider and the Division as to the status of the bill."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, TX 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 25, 2010	CPT Code 99456-W5-NM	$350.00	$350.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care

provider.

5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 1, 2010
   - 200 – PER 134.801, A MEDICAL BILL SHALL NOT BE SUBMITTED LATER THAN THE 1ST DAY OF THE 11TH MONTH (<08/31/05) OR 95 DAYS (>09/01/05) AFTER DOS.
   - 45 – THE TIME LIMIT OR FILING HAS EXPIRED.

Issues

1. Did any of the exceptions listed in Texas Labor Code §408.0272 apply to the medical services in dispute?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and 28 Texas Administrative Code §102.4?
3. Has the Maximum Medical Improvement (MMI) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
4. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds that the requestor has supported that the provider filed for reimbursement within 95 days after the date of service. The submitted documentation supports that the bills were confirmed sent to and received by the respondent via electronic submission on September 13, 2010. Per 28 Texas Administrative Code §102.4(h), documentation submitted by the requestor in this medical fee dispute sufficiently supports that a medical bill was submitted for payment to the insurance carrier within 95 days after the date on which the health care services were provided to the injured employee.

   Review of the submitted documentation finds that the requestor in this medical fee dispute has timely filed the medical bills with the insurance carrier in accordance with Texas Labor Code §408.027. The respondent's denial reasons are not supported. The disputed services will therefore be reviewed per the applicable Division rules and fee guidelines.
3. The requestor billed the amount of $350.00 for CPT code 99456-W5-NM with 1 (one) unit in Box 2G of the CMS-1500 regarding a Designated Doctor Examination for the injured worker not being at Maximum Medical Improvement (MMI) therefore no Impairment Rating was performed. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Review of the submitted documentation supports that the Division ordered this examination which is payable per Texas Labor Code §408.0041(h).
4. The respondent has previously reimbursed the amount of $0.00 for CPT code 99456-W5-NM. Therefore, the amount of $350.00 is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $350.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $350.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 3, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.